☐ *Borough Park* 1428 36th Street Suite 107 Brooklyn, NY 11218

☐ *Crown Heights* 555 Lefferts Avenue Brooklyn, NY 11225

☐ *Manhattan* 57W 57Street Suite 601 New York, NY 10019

☐ *Manhasset* 333 East Shore Road Suite 201 Manhasset, NY 11030

☐ *Rockville Centre* 165 North Village Avenue Suite 133 Rockville Center, NY 11570

☐ *Elmsford/ Terrytown* 555 Taxter Road 3rd Floor Elmsford, NY 10523

Office: 212-803-3339 Fax : 646-768-8600

☐ *Manhattan* 225 E 70th Street Suite 1E New York, NY 10021

☐ *Queens* 64-05 Yellowstone Blvd CF104 Forest Hills, NY 11375

☐ *Manhattan* 225 East 70th Street New York, NY 10021

☐ *Holbrook/ Ronkonkoma* 233 Union Ave Suite 207 Holbrook, NY 11741

☐ *Scarsdale* 495 Central Park Avenue Suite 205 Scarsdale, NY 10583

☐ *5 Towns* 141 Washington Avenue Cedarhurst, NY 11559

☐ *Long Beach* 917 Beech Street Long Beach, NY 11561

☐ *Riverhead* 1228 E Main Street Suite A Riverhead, NY 11901

MEDICATION ORDERS EVENITY
ROMOSOZUMAB (aqqg)

Date: ____________________

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal ☐ Discontinuation Order

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Age related Osteoporosis without current pathological fracture	ICD10 Code: M81.0
☐ Age related Osteoporosis with current pathological fracture	ICD10 Code: M8 0.0
☐ Other Diagnosis: ______________________________	ICD10 Code: ________________

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Serum calcium level	☐ DEXA scan results and/or FRAX score
☐ Documentation of oral hygiene	

List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates) :

1)

2)

MEDICATION ORDERS	
Dosing	☐ Evenity 210mg SubQ once monthly (given as two injections of 105mg each)
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

PRESCIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

ORDERING PROVIDER

Signature **X** ______________________________ Date ____________

Provider ______________________ Phone ____________ Fax ____________